Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012618	A. BUILDING _____ B. WING _____	12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAXIM HEALTHCARE SERVICES INC	2856 BUICK CADILLAC BLVD STE 4 BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This visit was for an initial home health state licensure survey. Facility #: 012618 Survey Dates: December 13-15, 2011 Medicaid Vendor #: N/A Surveyor: Marty Coons, RN, PHNS Maxim Healthcare Services Inc is in compliance with the Indiana State Rules for home health agency licensure 410 IAC Article 17 Quality Review: Joyce Elder, MSN, BSN, RN December 16, 2011	N 000		